BRIAN SANDOVAL
Governor

STATE OF NEVADA

TERRY JOHNSON
Director

SCOTT J. KIPPER
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.state.nv.us

FREQUENTLY ASKED QUESTIONS REGARDING ESSENTIAL HEALTH BENEFITS

What are Essential Health Benefits?
They are specific categories of health insurance benefits.

How many Essential Health Benefit categories are there?
There are ten Essential Health Benefits mentioned in the Affordable Care Act.

What are the Essential Health Benefit categories?

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services;
- Prescription drugs;
- Rehabilitation and Habilitation;
- Laboratory services;
- Preventive and wellness services; and
- Pediatric services

What are ambulatory patient services?
Ambulatory patient services are probably better known as “outpatient” services.

I understand what rehabilitation is, but what is habilitation?

If you think of rehabilitation as re-learning how to do something, such as re-learning to walk after knee surgery, then habilitation is learning how to do something for the first time, such as overcoming a speech impediment.

Why are Essential Health Benefits important?
There are two main reasons:

1. The Affordable Care Act requires most individual health insurance policies and most health insurance policies offered by small employers to cover the Essential Health Benefits; and
2. The Essential Health Benefits cannot have annual or lifetime dollar limits attached to them.

How are the Essential Health Benefits chosen?
Nevada will choose one "benchmark" insurance plan from ten choices and that benchmark plan will set the Essential Health Benefits for the State.

What about all of the benefits that are not Essential Health Benefits, like chiropractic care?
If the benchmark plan selected has other benefits on top of the Essential Health Benefits, those additional benefits will become Essential and must be included by many plans.

Wait, so you're going to dictate what insurance plan I have to have?
No. The benchmark plan will set the minimum insurance benefits that many insurance plans will have to offer but you will still be free to shop for insurance from any licensed insurance company you wish.

But you're going to set my deductible, copayment, and coinsurance, right?
No. Your deductible, copayment, and coinsurance (collectively called "cost sharing") are actually not directly related to the Essential Health Benefits.

You said there are no annual or lifetime dollar limits for Essential Health Benefits but you did not say anything about visit limits. What's the deal?
Insurance plans will be able to have visit limits on Essential Health Benefits but the limit cannot be lower than the limit in the benchmark plan.

So what insurance plans will have to offer the Essential Health Benefits?
All non-grandfathered individual and small group insurance plans must offer the Essential Health Benefits.

A small group insurance plan is typically offered through an employer and covers 2-50 people. A grandfathered plan is an insurance plan that existed on or before March 23, 2010 and that has not significantly cut benefits or increased costs.

I have insurance through my employer, which has more than 50 employees. Does this mean that I'm not eligible for the Essential Health Benefits?
No. If you have insurance through a plan with more than 50 participants or a plan which is self-funded then your insurance does not have to provide all 10 Essential Health Benefit categories. However, if your insurance does provide an Essential Health Benefit category, the benefits in that category cannot have annual or lifetime dollar limits.

So what does this all mean?
Let's use an example. Pretend that we have three health insurance plans, Plan 1, Plan 2, and Plan 3. All three plans cover physical therapy after a knee surgery. Plan 1 offers 20 physical therapy visits per year, Plan 2 offers 60 physical therapy visits per year, and Plan 3 offers unlimited physical therapy visits per year.

If Plan 1 is selected as the benchmark then physical therapy with a 20 visit maximum becomes an Essential Health Benefit. Plan 2 and Plan 3 do not have to change since their visit maximums are both greater than 20.

If Plan 2 is selected as the benchmark then physical therapy with a 60 visit maximum becomes an Essential health Benefit. Plan 1 will have to increase its visit limit from 20 to 60 and Plan 3 will not have to change.

If Plan 3 is selected as the benchmark then physical therapy with no visit limit becomes an Essential Health Benefit. Both Plan 1 and Plan 2 will have to eliminate their visit limits.

Why doesn't Nevada just choose the plan with the best benefits as the benchmark?
Better insurance coverage is more expensive; we must balance the benefits chosen against the cost to you. Also, not every plan may cover the same items. One plan may have the best benefit in one category and the worst benefit in another category, so the selection must be carefully weighed.